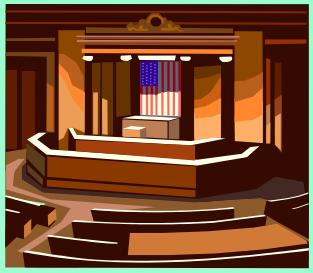
pbH

Piedmont Behavioral Healthcare

Creating solutions, One person at a time



Public Policy Considerations for North Carolina

Management structure for public systems:

- **Statewide: too large, challenges in making adjustments for local needs.**

- **Regional: more efficient than local, but still able to make adjustments specific to the needs counties within the region. Electronic communications and electronic management software are one reason that a regional system of management with local presence is now possible.**

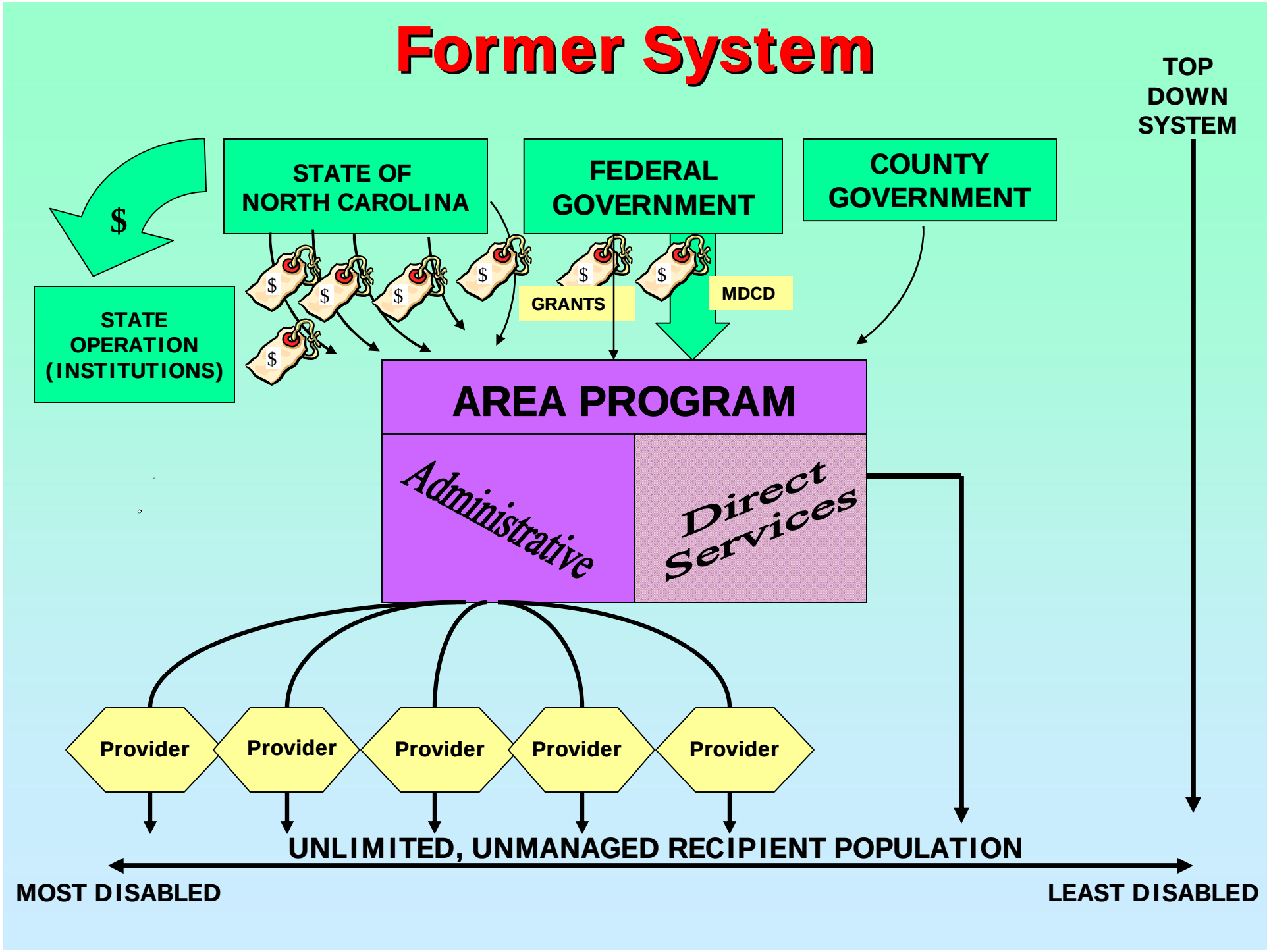
- **Local: very customized to local conditions but most counties are too small to provide the financial support needed to pay for the type of sophisticated infrastructure that is needed (IT, Quality, Management).**

Policy: Resource Management? yes or no

If yes, then the 1915 b/c waiver model demonstrated by PBH is the best model.

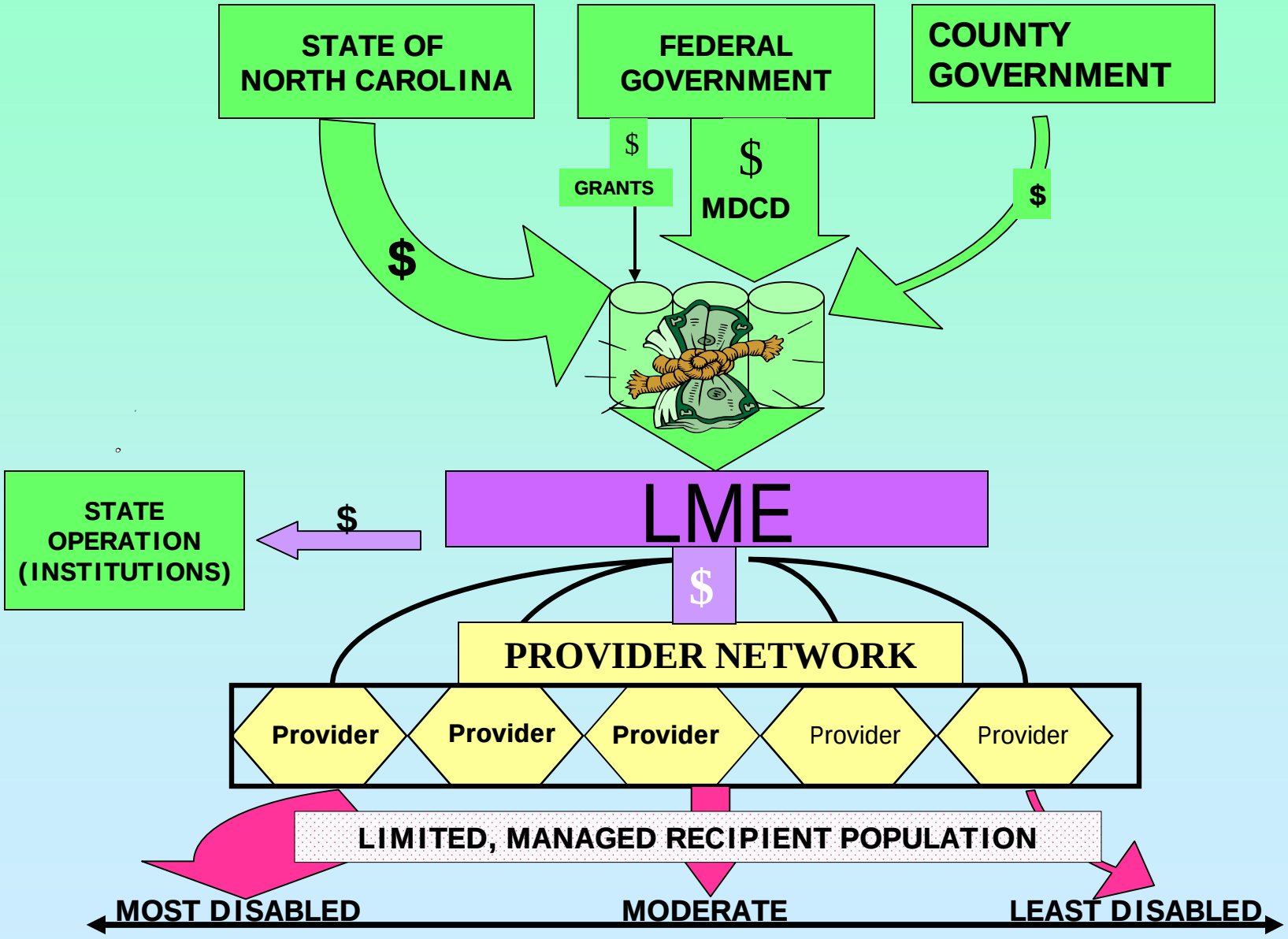
PBH is a public entity, there is no profit motive, and there are stringent requirements on how funding is managed and reported.

Former System



REFORMED SYSTEM

Two Way System



Managed Care in a Public System

- **The goal of managed care is <u>not to save money</u>.**
- **The goal is to <u>manage cost</u>, and control the rate of Medicaid growth.**

- **The goal is to manage care so that consumers are <u>efficiently</u> directed to <u>appropriate</u> services. This results in less average cost than in an unmanaged system (typical fee for service).**

As a waiver manager our Goal is to make sure consumers receive appropriate care, that no one is over-served, and more importantly that no one is underserved. We must provide these assurances to the State.

PBH Medicaid costs (capitation payments) are significantly below Medicaid fee for service costs for the rest of the state.

Comparison of historical State Fee For Service costs to PBH Capitation Payments						
	2006-2007		2007-2008		2008-2009	
	State FFS	PBH	State FFS	PBH	State FFS	PBH
B waiver costs only.	140.66	93.60	157.34	92.95	123.72	100.24
B and C waiver costs.	174.46	132.69	194.93	129.72	163.69	137.36

Comparison of historical State Fee For Service costs to PBH Capitation Payments			
	2006-2007	2007-2008	2008-2009
PBH Medicaid Capitation payments are less than state fee for service Medicaid costs by the percentages shown below for three consecutive fiscal years:			
Not including 1915 C waiver.	50.3%	69.3%	23.4%
Includes1915 C state fee for service costs compared to PBH capitation payments for the Innovations waiver.	31.5%	50.3%	19.2%

The Savings illustrated here are a by-product of our effort to do the right thing for consumers, and demonstrate the impact of appropriate management against unmanaged services.

PBH has a low denial rate for Service Requests:

Treatment Authorization Requests (TAR):

Completion Rate:	Oct'09	Nov'09	Dec'09	Jan'10
Total Number of TARs Submitted	4,095	3,968	4,148	4,193
Number Reviewed within 14 Days	3,879	3,783	3,954	4,025
Compliance Rate	94.7%	95.3%	95.3%	96.0%
Average # of Days to Review TAR	4	4	4	3
Total TARs Approved	3,327	3,174	3,363	3,411
Total TARs Pended	768	794	785	782
Total TARs Denied	11	25	34	25
% Denied	0.3%	0.6%	0.8%	0.6%

A managed system coordinates

- People
- Resources
- Benefits
- Outcomes

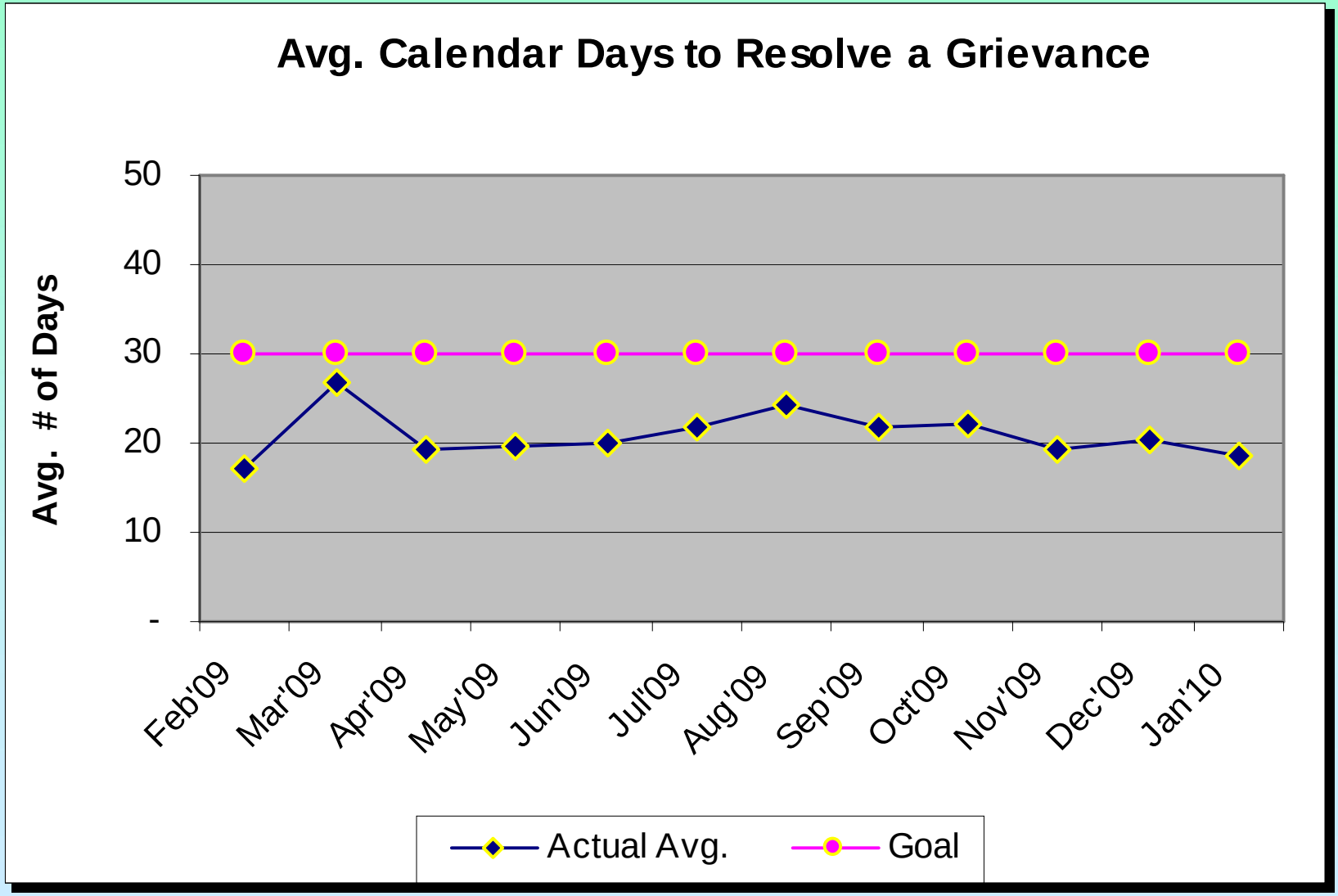
And reaches out to consumers with special needs to ensure they receive the care that they need.

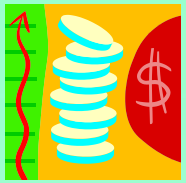
Managed Care Tools:

- ***Capitation*** **provides local flexibility and control of resources**
- ***Payor of claims*** **ensures that funds are spent in accordance with authorizations**
- **Rate setting authority allows us to adjust rates according to local conditions**
- ***Closed Network*** **allows for competition and choice while rightsizing the marketplace; ensures health of providers**
- ***Utilization Management*** **gives us the tools to ensure consumers receive both the appropriate service and amount of treatment to meet their needs.**
- ***Care Coordination*** **is an important activity that directly intervenes to ensure consumers that have high needs receive appropriate care. Care Coordinators work with consumers, providers and other healthcare systems.**

Balance in the System

Managed Care Roles and Responsibilities	Consumer Alternatives and safeguards required for Medicaid Managed Care Waivers
Easy Access	A consumer may enter the system through any enrolled provider or the PBH 1-800 number. PBH has over 200 enrolled providers.
Authorization of the type and amount of services	If the consumer does not agree: • Local Reconsideration • Formal Appeal Option through Office of Administrative Hearings • Providers may advocate for consumers
Quality Services and Quality of PBH Management	If the consumer is dissatisfied: • Grievance Tracking and Response System with goal of resolving grievances within 30 days. This is closely monitored by the Division of Medical Assistance. • Consumer may call the Division of Medical Assistance.
Health and safety assurances	Concerns: reported by consumers, providers and the public at large • Waiver manager investigations • DHSR investigations (for licensed facilities) • Incident Reporting and submission to DMA and DMH/DD/SA


Avg. Calendar Days to Resolve a Grievance
Avg. # of Days
50
40
30
20
10
-
Feb'09
Mar'09
Apr'09
May'09
Jun'09
Jul'09
Aug'09
Sep'09
Oct'09
Nov'09
Dec'09
Jan'10
Actual Avg.
Goal



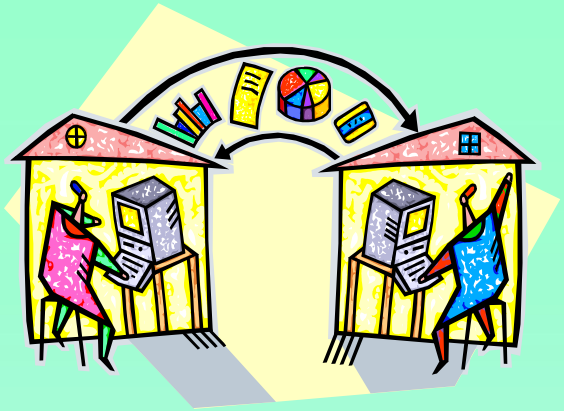
The Managed Care Service Continuum

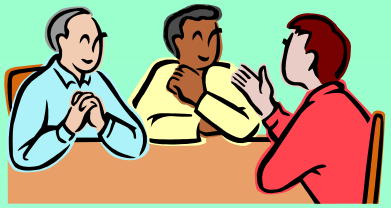
- **The key to a successful financial model in Managed Care, is that all financial resources, from the lowest level of care, to the highest level of care are included in the waiver.**

- **This allows the managing entity to balance costs across a system of care.**

- **Having both high cost intensive services and low cost least restrictive services in the same financial plan provides motivation to serve consumers at the least restrictive, but appropriate level of care.**

- **Consumers that do not receive adequate care and thus present problems to the community, present in the Emergency Department, or require high levels of intervention such as psychiatric hospitalization are identified through population monitoring strategies called Care Management. Care Coordinators provide hands on intervention to ensure high need or at risk consumers receive the care they need. Many such consumers need assistance in order to access care.**



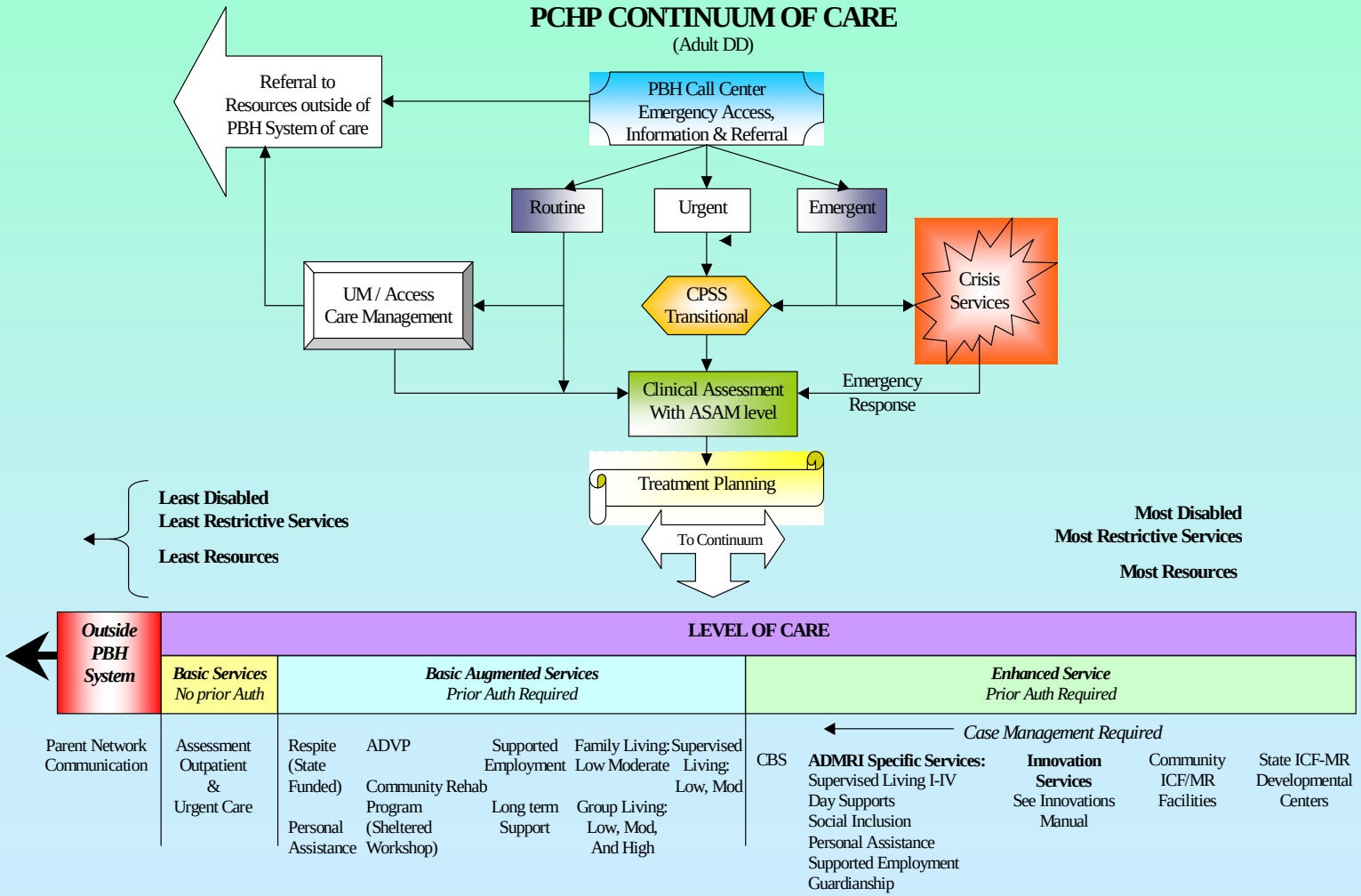


- **Consumers that are a level of care that is higher than is needed, are also identified by regular review of functional status, risk, and length of time of services at a high level of care.**

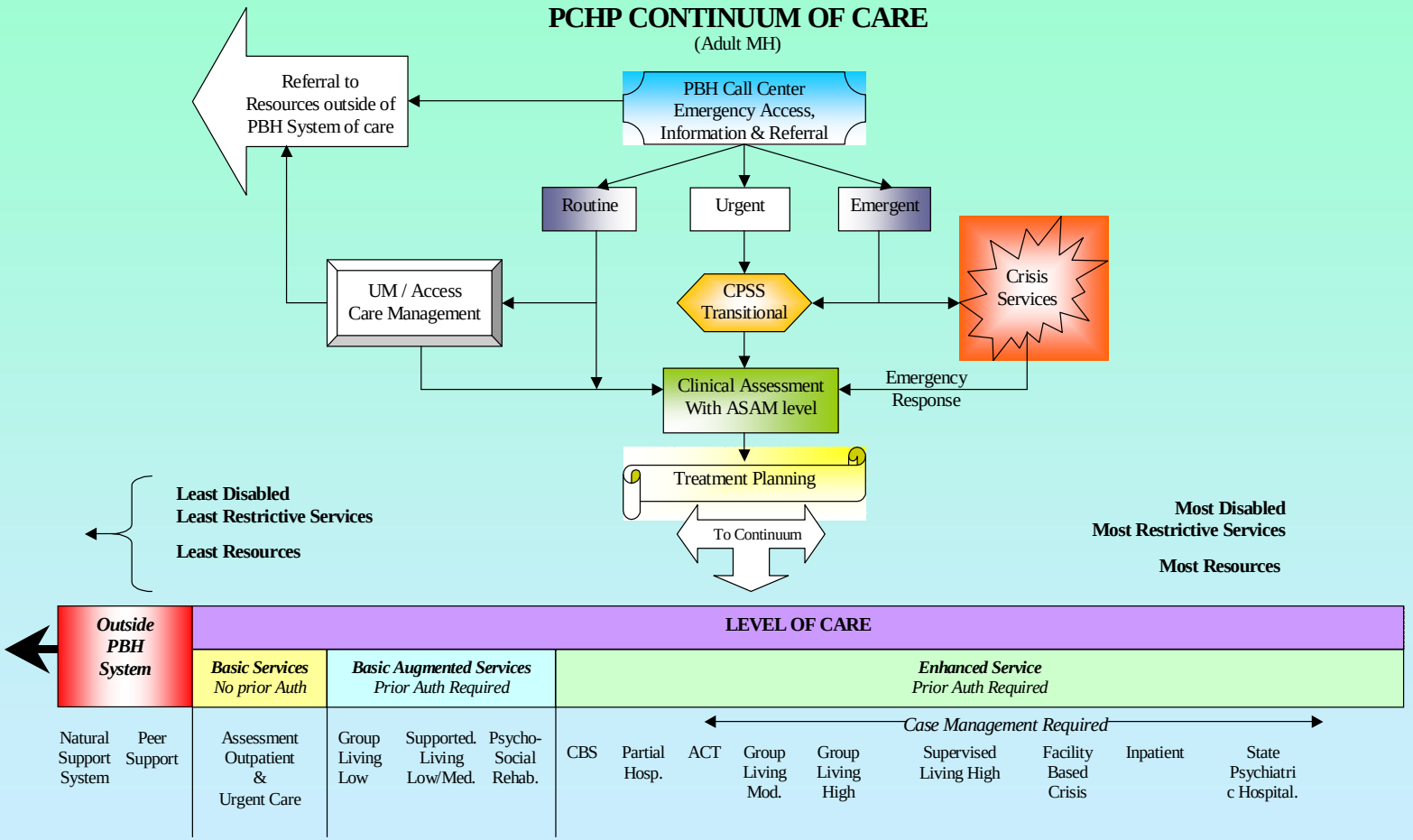
- **Having the entire continuum under a single Manager, provides motivation and ensures accountability that people are directed to the most appropriate service (or level of care) to meet their needs. And, that when the person improves, they are transitioned to less intense services.**

- **This is why it is important to have Psychiatric Hospitalization and Medical Detoxification in the MH/SA Continuum of care and Intermediate Care Facilities (ICF-MR) in the DD Continuum of care.**

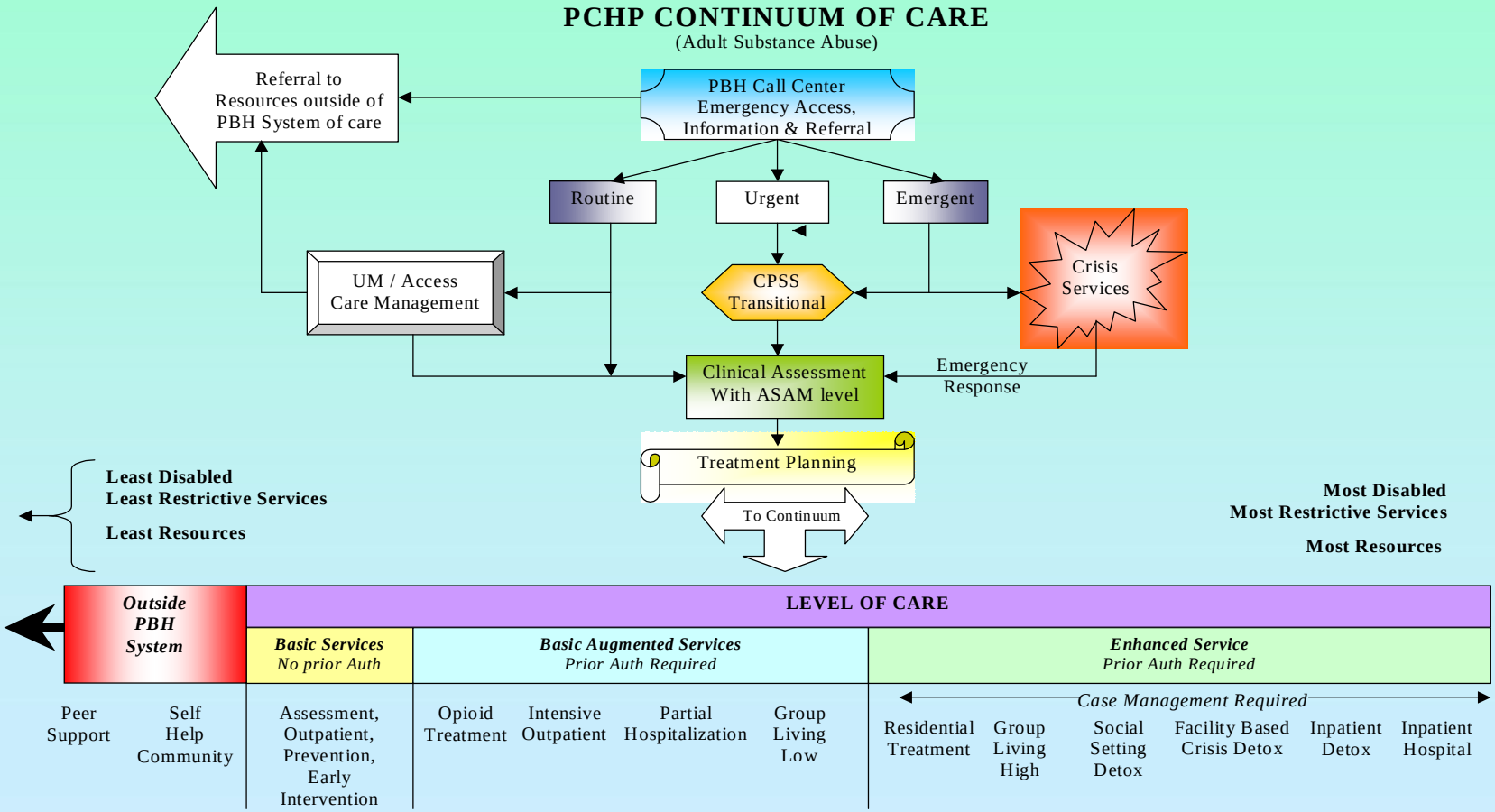
ADULT DD CONTINUUM



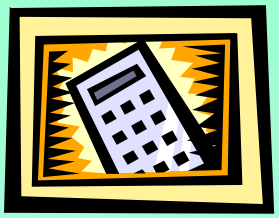
ADULT MH CONTINUUM



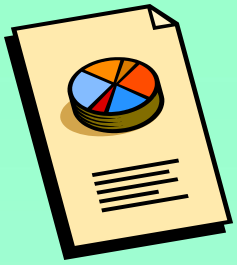
ADULT SA CONTINUUM



Policy: System Accountability



- If a rationale, accountable system of care is the goal, then a system that associates level of need with a specific amount of services is the answer.
- Managed Care, works differently in public systems than in commercial insurance systems, because the goals are different.
- There is a relationship between the person's level of need/risk and the amount and scope of the services provided.
- The goal is that the relationship between level of need/risk and amount of services is *consistent across the system* for consumers experiencing the same diagnosis, or degree of need or risk.



Challenges in Managing Care

- In general, consumers with similar conditions and needs should receive similar amounts and types of services.

- There should be consistency across a system of care.
- There should be a fair process for evaluating requests for services, with clear criteria for decisions.

The process for assessing and evaluating need is very different for consumers with MH/SA conditions vs. consumers with DD conditions

Mental Health and Substance Abuse System:

This is a diagnosis driven system. The diagnosis is critical in determining the course of treatment, and is guided by Clinical Practice Guidelines.

This is why a good clinical assessment is so important.

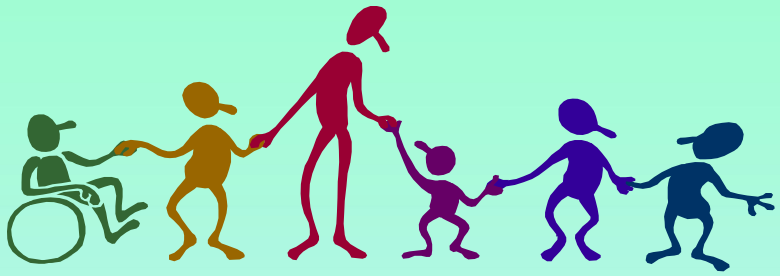
Service utilization is also largely predictable based on the diagnosed condition, functioning level of the individual, and level of risk.

Sometimes this is called a Medical Model.

This model is well understood by Mental Health and Substance Abuse practitioners.

Therefore PBH and MH/SA providers approach treatment from a similar perspective.

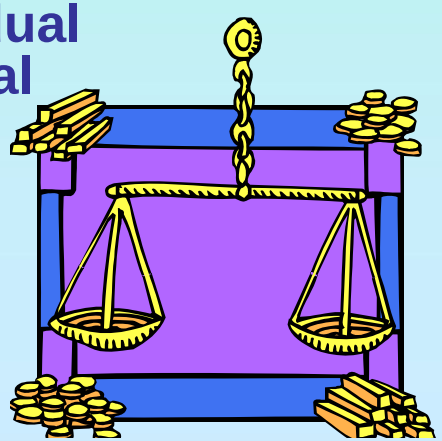
Managing Care for People with Developmental Disabilities



- In DD systems, the diagnosis is only important in establishing eligibility for services.
- The level of need is the most important factor in determining the amount of services a person requires.
- Need is a combination of the person's functional skills, risk behaviors, medical condition, living situation, and amount of natural supports.

Measuring Need in Developmental Disabilities Systems of Care

- PBH uses Psychological Evaluations and Adaptive Behavior Assessments to determine whether a person is eligible for services.
- We use the Supports Intensity Scale to measure the level of need. This assessment is not focused a person's disabilities, it is focused on how much support a person needs.
- The Supports Intensity Scale is a proven individual evaluation system for people with developmental disabilities and is used in many states for the purpose of measuring need.



Authorizing Care in Developmental Disability Systems—we are still learning:

- **Last year, as part of an extensive evaluation process, PBH discovered that there was no consistency in the amount of services approved among consumers with developmental disabilities when the person's level of need and amount of services were correlated.**

- **Based on this information, our goal is to develop a system to ensure that we are fair and consistent in authorizing services and supports for people participating in the Innovations waiver.**

- **Although the approach to achieving this goal for the Innovations Waiver will be very different from the process we use for consumers with Mental Health and Substance Abuse conditions, it is equally important to establish a clear model that is well understood by every one involved: consumers, families, providers and PBH staff.**

Closed Provider Network

- The primary purpose of a closed network in public Managed Care, is to ensure that participating providers have enough market share to make necessary investments in infrastructure such as quality and information management.
- This also results in a high level of cooperation among provider agencies because their primary focus is not on obtaining more market share.
- Cooperation among PBH providers includes strong support for:
  - a Provider Council that has operated for nearly six years
  - a Global CQI Council that focuses on quality initiatives across the PBH Network
  - Cultural Competency initiative that has informed the training process, provided provider to provider assistance in developing Cultural Competency Plans, and collaborated with PBH on development of a Cultural Competency Monitoring Tool.
- There is enough competition to influence quality, but not so much that providers must continually focus on their survival.
- There are sufficient providers to offer choice to consumers.
- PBH has a closed network with 232 enrolled providers.

A Stable Business Environment

A closed network also helps to achieve a stable and predictable business environment.

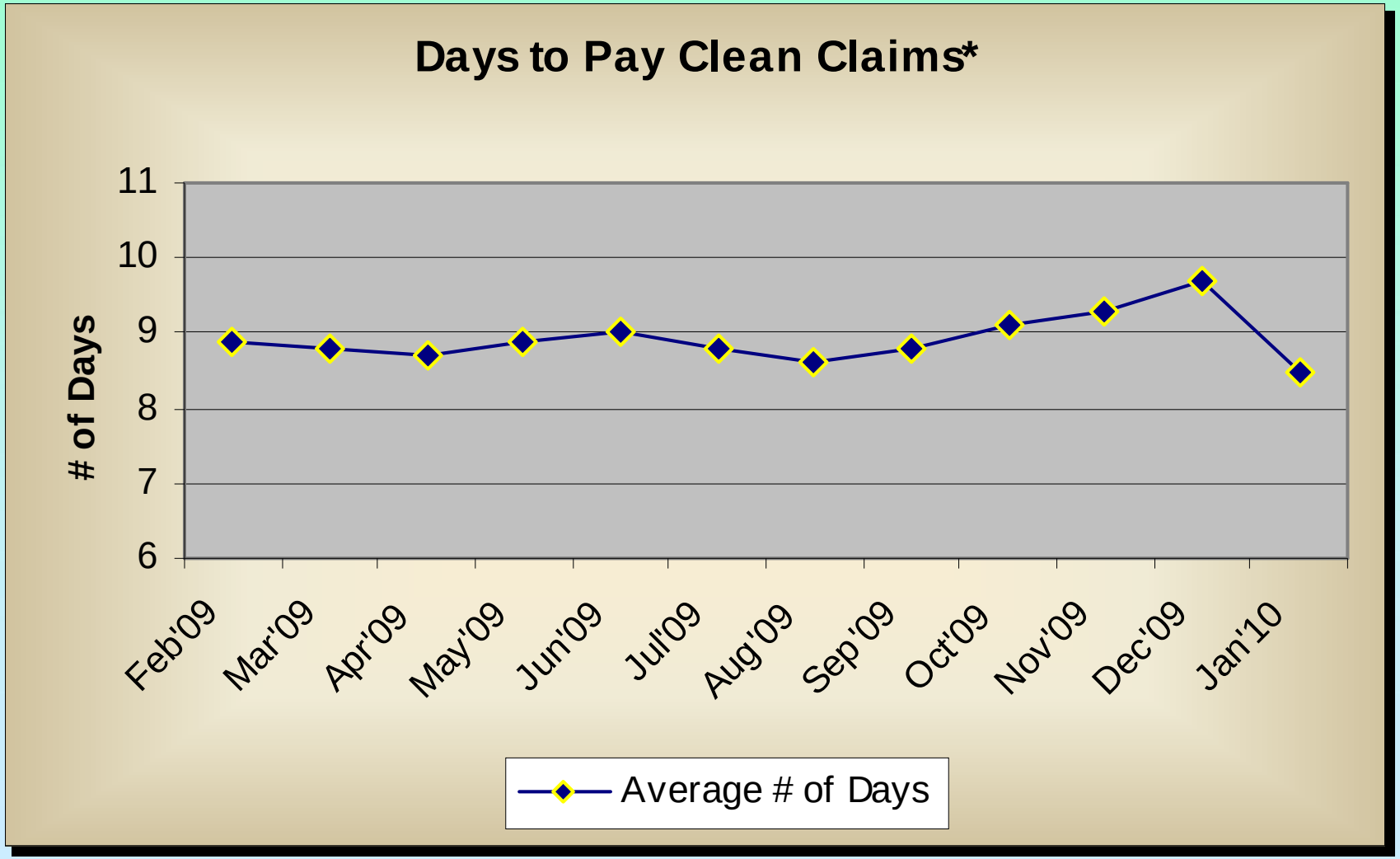
Evergreen contracts provide continuity for providers. Evergreen contracts do not need to be renewed annually. These contracts are active unless a provider voluntarily withdraws from the network or is terminated for poor quality services or performance problems such as compliance with Medicaid regulations.

The PBH Provider Network Is made of 232 Contracted providers. These providers include Comprehensive Care Providers (CCP), Agencies (single and multi-service), Group Practices, Individual Practices, Hospital Inpatient Services, and Hospital based outpatient services. There are currently 103 DD providers. The following chart shows the number of providers by provider type in the Network.

Type of Contract Provider	# of Providers
Agency	118
CCP	4
Group	25
Hospital Inpatient	7
Hospital Outpatient	3
Individual	73
pbh	2
Special	2
Total Providers	**234**
Total Contracted Providers	**232**

PBH Business Support for Providers

- **Valid and clean claims are paid within 10 days of submission.**
- **PBH accepts standard electronic claims.**
- **PBH offers a web based billing tool that supports small providers that do not use electronic billing software.**
- **PBH provides hands on assistance for providers---we want providers to submit claims successfully. This is more cost effective for <u>both</u> PBH and Providers.**


Days to Pay Clean Claims*
# of Days
11
10
9
8
7
6
Feb'09
Mar'09
Apr'09
May'09
Jun'09
Jul'09
Aug'09
Sep'09
Oct'09
Nov'09
Dec'09
Jan'10
Average # of Days

Accessibility Study

Calendar Year 2008 Data:

Availability of Providers by Type of Providers and Geographic Distribution

There are approximately 167,168 enrollees who are eligible for services under the Piedmont Cardinal and Innovations plans. 159,214 of these enrollees live inside the PBH Catchment Area (Cabarrus, Davidson, Rowan, Stanly, and Union Counties). On average, between 15% (25,000) and 17% (29,000) of eligible enrollees actively receive services from the PBH Provider Network annually.

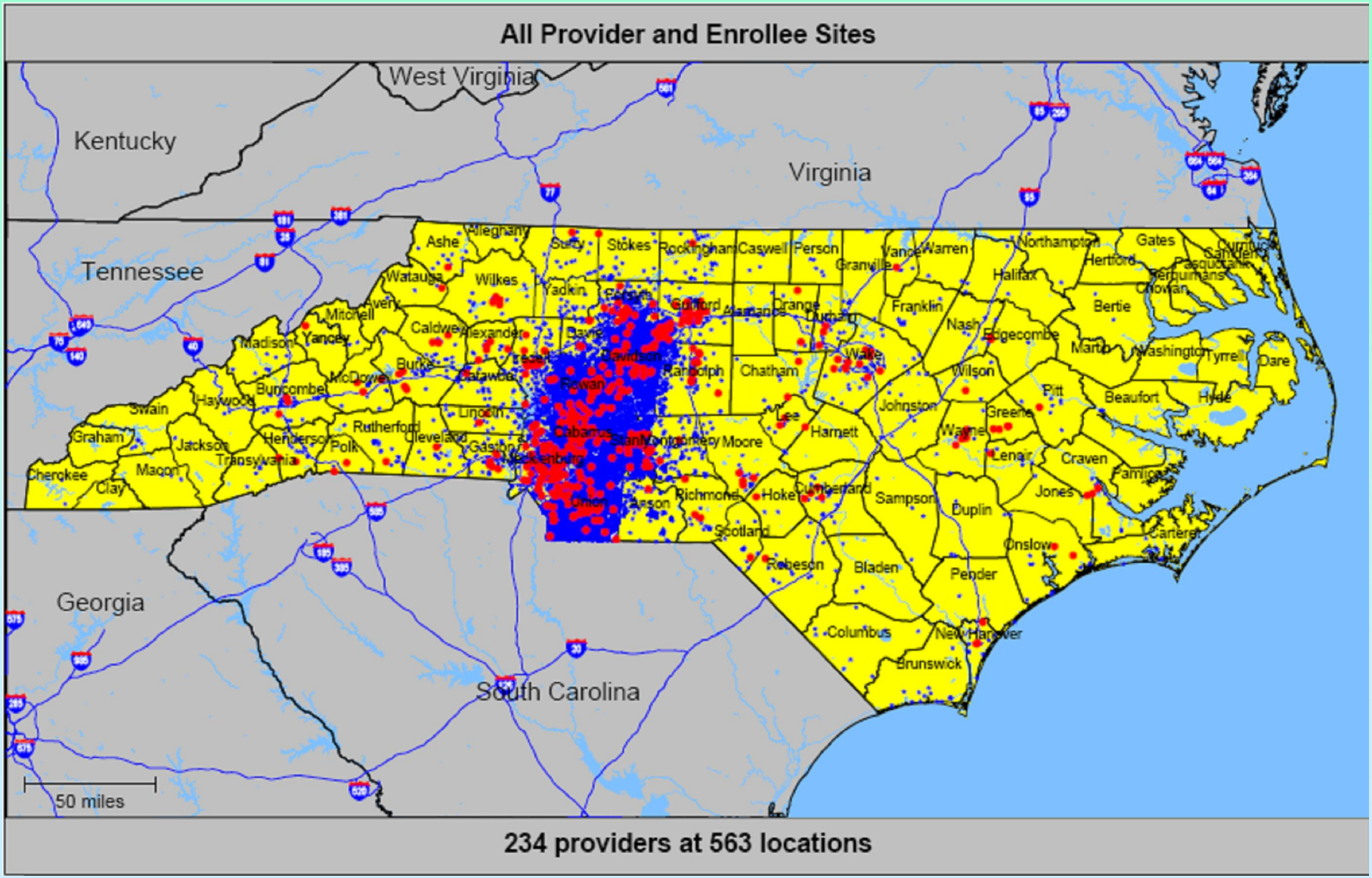
Accessibility Study

Calendar Year 2008 Data:

Based on 2008 data estimates from the United States Census Bureau all counties in PBH's catchment area are classified as rural. Access standards for the PBH Network are as follows:

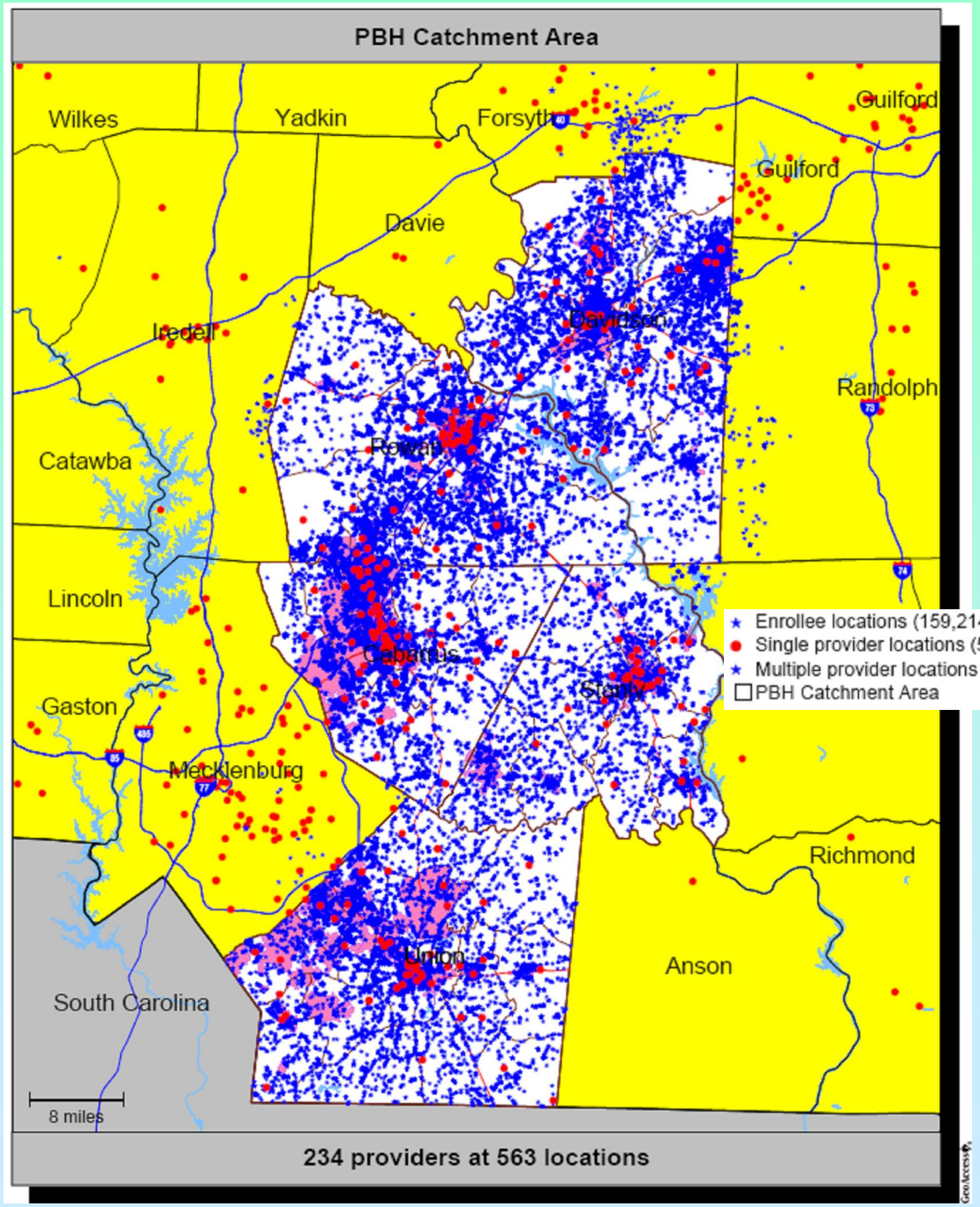
•Percent of open Psychiatrists	•60% open
•Psychiatrist/member ratio	•1 Psychiatrists/1000 enrollees actively receiving services
•Licensed Independent Practitioners (LIP) not including psychiatrist/member ratio	•4 LIPs/500 enrollees actively receiving services
•Geographic distribution of Psychiatrist and LIPs to each member	•1 open Psychiatrist and 1 other type of LIP within 45 miles/ 45 minutes (rural)
•Geographic distribution of Psychiatrist and LIPs to each member	•1 open Psychiatrist and 1 other type of LIP within 30 miles/ 30 minutes (urban)
•Geographic distribution of CCPs to each member	•(1) CCP within 20 miles/20 minutes
•Geographic distribution of residential facilities	•1 facility within 100 miles/100 minutes
•Behavioral health facility (inpatient psychiatric, crisis unit, detoxification unit, or substance abuse residential care).	•1 within 75 miles/75 minutes

Accessibility Study: 2008 Statewide

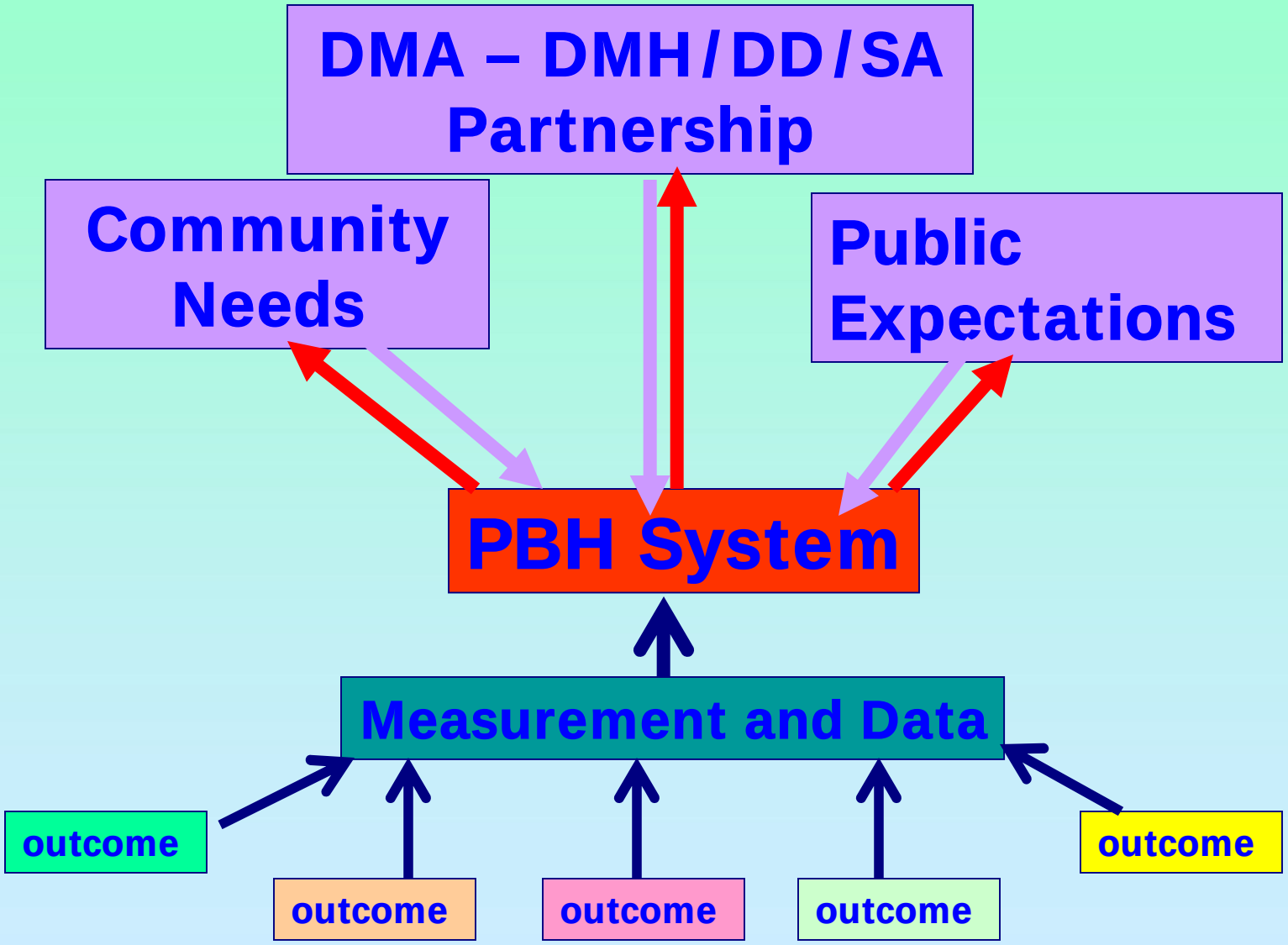


Accessibility Study: 2008

PBH Counties



Accountability

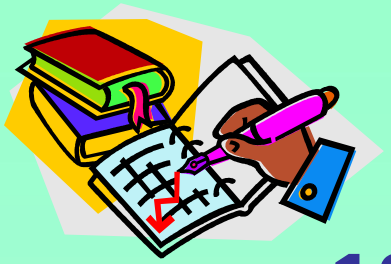


State Oversight

- As managed care entity, PBH shares with the state responsibility for calculating and reporting on performance indicators

- Quarterly, annual and semi-annual reporting

- PBH has also achieved full accreditation by NCQA, the highest level of accreditation for a managed care entity.

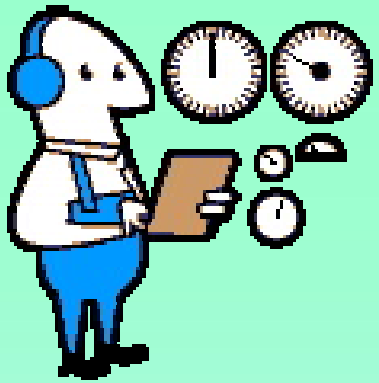


Additional State Oversight Requirements

- 1915(c) waiver subject to 1915(b) waiver requirements and managed care regulations

Extensive Reporting to the State that includes:

- Performance and utilization measures (PMs)
- Performance improvement projects (PIPs)
- Consumer & provider surveys
- Grievance & appeals reporting



Accountability

PBH has over 60 individual performance measures that are reported to DMA and DMH monthly or quarterly.

These measures relate to quality of care, how services are used, and how we manage funding.

Additional State (DMA) Oversight Requirements

- External quality review activities occur annually for:
  - Contract compliance review
  - Validation of Performance Improvement Projects

- Independent assessment:
  - Quality of care
  - Access to care
  - Cost effectiveness

- Annual on-site review by state

"PBH has successfully completed the transition from a provider of care to a capitated managed care organization. There is clear evidence that PBH has impacted access, quality, and the cost of services for members. Other demonstrated areas of success related to managed care operations are noted below:

- Utilization Review…….
- Quality Management……..
- Credentialed Provider Network……..
- Use of data for managing eligibility, claims, clinical activities and administrative operations……."

Mercer Consulting on behalf of the NC DHHS Intradepartmental PBH Monitoring Team: Second Annual Review, October, 2007

PBH is a successful demonstration model of public management of a system of care that has oversight for <u>all public resources</u> in a given geographic area.

We have specialized in management functions:

- **System efficiencies**
- **Consumer outcomes**
- **Satisfaction**
- **Quality**

Management of operations in order to:

Assure partnerships with a competent provider network

Establish a predictable business environment that will keep provider partners strong.

As a direct result of the PBH success story, Secretary Cansler has decided to expand the PBH model and waivers to other LMEs!